

**SAMPLE FORM FOR RECORDING
SUSPECTED SEIZURES**

SOURCE OF SAMPLE FORM: **NEUROPSYCHIATRIC CLINIC FOR PEOPLE WITH DEVELOPMENTAL
DISABILITIES**

"Spell" Record Form

Name: _____

Was this a typical spell? YES NO

Date: _____/_____/_____

Exact time of spell: _____

How long did spell last? _____

1. How did the person behave before the spell? (Describe, don't label)

Consider:

- * What was the person doing at the time before or very beginning of spell?
- * What was happening in environment before at beginning of spell?
- * Had the person just awoken from a nap, just fallen asleep; how long sleeping?
- * What called your attention to the spell? (Cry out, fall, stare, movements, head turn, etc.)

How did the person behave during the spell?

Consider:

- * How did the spell develop (gradual/rapid onset, one part of body, etc.)
- * Were there body movements? (Rigid, jerks, twitches, convulsions, did eyelids flutter or roll)
- * What part of the body moved first, second, etc. Did breathing change
- * Did the person lose control of bowel or bladder
- * Did the skin show change (clammy, flushed, pale, blue, etc.)
- * Did the person talk or perform action during the spell *Did they hurt themselves
- * Could you get the person's attention during spell (respond to voice or touch, etc.)

SAMPLE FORM FOR RECORDING Form S1-9
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How did the person behave after the spell?

* Confused * Sleeping/sedate * Talkative * How long did it take to recover from spell?

What was the reaction of bystanders, if any, after the spell?

Additional information.

Consider:

- * Was the person sick or did they have a fever * How is this different than previous spells
- * When was the persons last dose of medication before the spell
